STATE OF MICHIGAN

IN THE SUPREME COURT

ADVOCACY ORGANIZATION FOR PATIENTS & PROVIDERS, a non-profit Michigan corporation et al,

Plaintiffs-Appellants,

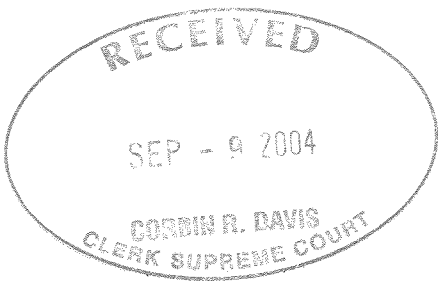
v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan corporation et al,

Defendants-Appellees.
_____/

Supreme Court Docket No. 124639
Court of Appeals No. 231804
Eaton County Circuit Co. No. 96-1409-CZ

BRIEF OF AMICUS CURIAE THE PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA



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Dated: September 9, 2004

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STATEMENT OF JURISDICTION

Defendants/Appellees' statement of jurisdiction is complete and correct.

STANDARD OF REVIEW

Defendants/Appellees' statement of the standard of review is complete and correct.

COUNTER-STATEMENT OF QUESTION INVOLVED

I. WHETHER MICHIGAN NO-FAULT INSURERS HAVE THE RIGHT AND OBLIGATION TO REVIEW MEDICAL BILLS FOR REASONABLENESS AND NECESSITY, AND TO PAY AMOUNTS LESS THAN THOSE BILLED BY MEDICAL PROVIDERS TO THE EXTENT THOSE AMOUNTS ARE DETERMINED TO BE UNREASONABLE OR UNNECESSARY.

Trial Court answered: Yes.

Court of Appeals answered: Yes.

Plaintiffs/Appellants answer: No.

Defendants/Appellees answer: Yes.

Amicus curiae answers: Yes.

INTRODUCTION AND INTEREST OF AMICUS CURIAE

The Property Casualty Insurers Association of America ("PCI") is a national insurance trade association representing more than 1000 property and casualty insurance companies across the country. The PCI member companies range in size from large national companies to regional companies to companies writing in a single state. The purposes of the PCI are to promote the economic, legislative and public standing of its members and the insurance industry; to provide a forum for discussion of problems which are of common concern to its members; to keep members informed of regulatory and legislative developments; and to serve the public interest

through appropriate activities, including the promotion of safety and security of persons and property.

The PCI member companies' insurance writings represent 38 percent of the country's total property and casualty market, and they account for 48.2% of all personal auto premiums written in the United States. In 2002, PCI members accounted for 51.2% of the personal automobile insurance policies issued in Michigan. Thirty-five (35) PCI members are domiciled in Michigan. Given this presence in the Michigan marketplace, PCI submits that the issues presented in this case are of great importance for all its members, as well as all insureds in the State of Michigan.

On July 3, 2003, based on the plain language of the Michigan No Fault Act and numerous decisions by this Court and the Michigan appellate courts construing the no fault scheme, the Court of Appeals affirmed the trial court's holding that Michigan insurers are entitled to review medical bills to determine whether they are reasonable and necessary. In so ruling, the Court of Appeals rejected plaintiffs' central argument that, as medical providers, they can charge any fee they want for their services to no-fault patients, so long as that fee does not exceed what they customarily charge to patients not covered by insurance.

On appeal before this Court, plaintiffs mischaracterize the Court of Appeals' ruling as giving a blanket seal of approval to one method (out of many) of assisting insurers in reviewing medical bills – *i.e.,* the "80th percentile test." The Court of Appeals, however, did *not* hold that this method, or any particular method, is the *only* method insurers may use to evaluate reasonableness, or that such a method, or any other method, is always appropriate. Rather, the Court of Appeals merely addressed the only issue plaintiffs have raised in this case, and held, consistent with the Michigan No-Fault Act and case law, that insurers have the right, indeed the obligation, to: (1) review medical bills for reasonableness and necessity; and (2) pay only

amounts determined to be reasonable and necessary (but subject to suits in individual cases if particular determinations of reasonableness or necessity are potentially wrongful).

If the Court of Appeals' decision is reversed, Michigan no-fault insurers' ability to audit and challenge medical expenses – a vital cost-policing function that this Court and numerous Michigan appellate courts have repeatedly found furthers the legislative goal of containing no-fault premiums – would be severely compromised. The negative effect on the Michigan insurance industry would be significant, because the costs to insurers of providing no-fault insurance, and the corresponding premiums they must charge their insureds, would no doubt increase substantially. To avoid this unfortunate result, the Court of Appeals' decision should be affirmed in all respects.

COUNTER-STATEMENT OF FACTS

The PCI adopts the Counter-Statement of Facts set forth by Defendants/Appellees.

ARGUMENT

I. THE COURT OF APPEALS CORRECTLY RULED THAT, UNDER SETTLED MICHIGAN LAW, NO-FAULT INSURERS HAVE THE RIGHT AND OBLIGATION TO REVIEW MEDICAL BILLS, SINCE SUCH BILL REVIEW FURTHERS THE PURPOSES OF THE NO-FAULT ACT.

Plaintiffs' central argument throughout this case, which is repeated in their merits brief to this Court, has been that, as medical providers, they may charge whatever fee they deem appropriate – *i.e.,* their customary charge – so long as they charge each of their uninsured patients the same fee. The Court of Appeals' rejection of this argument, and its holding that insurers have the right and duty to review medical bills for reasonableness and necessity, is wholly supported by the Michigan No Fault Act and case law, and clearly furthers the purposes of the No Fault Act.

The No Fault Act plainly provides that insurers must pay *only* for medical expenses that are reasonable and necessary. *See, e.g.*, MCL 500.3107(1)(a) ("personal protection insurance benefits are payable for the following: (a) Allowable expenses consisting of all *reasonable charges* incurred for *reasonably necessary products, services and accommodations* for an injured person's care, recovery, or rehabilitation") (emphasis added). The Act further provides:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, *may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.*

MCL 500.3157 (emphasis added).

Construing the Act, this Court expressly held, in a case almost wholly ignored by plaintiffs throughout this lawsuit, that, "[u]nder this statutory scheme, an insurer is not *liable* for any medical expense to the extent that it is not a reasonable charge for a particular product or service, or if the product or service itself is not reasonably necessary." *Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 48-49, 457 NW2d 637, 645 (1990). This Court explained, the "plain and unambiguous language of § 3107 makes both reasonableness and necessary explicit and necessary elements of a claimant's recovery, and thus renders their absence a defense to the insurer's liability. In addition, the burden of proof on these issues lies with the plaintiff." *Id.* As this Court further stated:

> [I]t is *each particular expense that must be both reasonable and necessary. The concept of liability cannot be detached from the specific payments involved, or expenses incurred*[.] The statute requires that three factors be met before an item is an allowable expense: 1) the charge must be reasonable, 2) the expense must be reasonably necessary, and 3) the expense must be incurred. These are the standard requirements for recovery of such expenses under all no-fault plans. . . . *Where a plaintiff is unable to show that a*

> *particular, reasonable expense has been incurred for a reasonably necessary product and service, there can be no finding of a breach of the insurer's duty to pay that expense, and thus no finding of liability with regard to that expense.*

Id. at 50, 457 NW2d at 645 (emphasis added, citations and internal quotations omitted).

So, this Court, in *Nasser*, has already answered the sole question raised by this case. *Nasser* makes it clear beyond doubt that Michigan insurers can, and should, review medical bills, and can, and should, decline to pay amounts charged by providers that are determined to be unreasonable or unnecessary.

Similarly, in *LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577, 582, n3, 543 NW2d 42, 44 n3 (1995), *app denied*, 453 Mich 930 (1996), the court stated that, under the No Fault Act, Michigan insurers are responsible only for reasonable charges incurred for reasonably necessary services. And the court further noted the "Legislature has decreed that a health care provider cannot lawfully charge more than a reasonable amount for ... products, services, and accommodations." *Id.*

In *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55, 535 NW2d 529 (1995), the court explained:

> We note that the absence of contractual limitations in no-fault situations does not give health-care providers liberty to charge no-fault insurers any amount. In addition to the "customary charge" limitation discussed above, §§ 3107 and 3157 also impose a statutory qualification of reasonableness, such that *a no-fault carrier is liable only for those medical expenses that constitute a reasonable charge for the product or service.*

Id. at 114, 535 NW2d at 557 (emphasis added); *see also Kallabat v State Farm Mut Auto Ins Co*, 256 Mich App 146, 151, 662 NW2d 97, 100 (same principle).

And in *Spect Imaging Inc v Allstate Ins Co*, 246 Mich App 568, 575, 633 NW2d 461, 465 (2001), the court reiterated the principle that insurers are not liable for unreasonable or unnecessary medical expenses, and that insureds have the burden of proving each expense is

reasonable and necessary. Applying that principle, the *Spect* court held: "[t]he record here does not contain evidence to support plaintiff's assertion that each particular expense stemming from plaintiff's performance of brain SPECT imaging on defendants' insureds was reasonable and necessary. Plaintiff has failed to put forth any evidence addressing the condition of each individual insured, the injuries suffered, or the need for a brain SPECT scan relating to each individual. On this record, we cannot say 'with certainty' that brain SPECT scans were reasonably necessary expenses in the treatment of each insured." *Id.* at 576, 633 NW2d at 466 (*citing Nasser*).

In other words, under the plain language of the No-Fault Act and vast Michigan precedent construing it, providers cannot charge, and insurers must not pay, medical expenses that are unreasonable or unnecessary. So, in ruling that insurers have the right to review medical bills for reasonableness and necessity, and are not required to pay the portion of bills determined to be unreasonable or unnecessary, the Court of Appeals reached the only conclusion it could have under settled Michigan law.

Moreover, the Court of Appeals' ruling clearly furthers the public policy underlying the No Fault Act. As this Court explained, the "legislative objective [of the Act] is the containment of the premium costs of no-fault insurance." *Davey v Detroit Auto Inter-Insurance Exch*, 414 Mich 1, 10, 322 NW2d 541, 545 (1982) (citations omitted). *See also Gooden v Transamerica Ins Corp of America*, 166 Mich App 793, 800, 420 NW2d 877, 880 (1988) ("The basic goal of the no-fault insurance system is to provide individuals injured in motor vehicle accidents assured, adequate and prompt reparation for certain economic losses at the lowest cost to the individual and the system") (citations omitted); *Spect*, 246 Mich App at 577, 633 NW2d at 467 (insurers "are not required to accept health care providers' unilateral decisions about what

constitutes reasonable medical expenses, because to do so would undermine the Legislature's purpose in enacting §3107").

In fact, Michigan courts have emphasized that, to further this legislative goal, insurers are required to police costs, and to do so by conducting the very bill reviews about which plaintiffs complain. For example, as one court noted:

> [W]e reject plaintiffs' argument that, pursuant to the no-fault act, defendants are obligated to pay the entire amount of plaintiffs' medical bills. Such an interpretation would require insurance companies to accept health care providers' unilateral decisions regarding what constitutes reasonable medical expenses, effectively eliminating insurance companies' cost-policing function as contemplated by the no-fault act. This result would directly conflict with the Legislature's purpose in enacting the no-fault system in general and § 3107 in particular. [I]t is clear that the Legislature did not intend for no-fault insurers to pay all claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud.

McGill v Auto Club Ins Ass'n, 207 Mich App 402, 408, 526 NW2d 12, 15 (1994) (citation and internal quotation omitted).

The *McGill* court further explained the No Fault Act "clearly indicate[s] that an insurance carrier need pay no more than a reasonable charge and that a health care provider can charge no more than that." *Id.* at 406, 526 NW2d at 15. Quoting this Court's decision in *Nasser,* the *McGill* court stated "[i]n theory, the insureds could be sued for the difference between what the carrier will pay and what the provider demands, but it is unlikely that the insureds would be liable for those expenses. As the Supreme Court noted in *Nasser*: . . . It seems unlikely that plaintiff would have an express agreement with [the doctor] or the hospital to pay unreasonable and unnecessary medical expenses, and equally as unlikely that he would have an implied contractual duty to do so. And, while we need not resolve the issue in this case, it seems unlikely that medical expenses found to be unreasonable or unnecessary in a no-fault action would be

found recoverable in a contract action against plaintiff." *Id.* (*quoting Nasser*, 435 Mich at 55 n10, 457 NW2d at 648 n10) (citations and internal quotations omitted).

Similarly, in *LaMothe, supra,* the court held that if an insurer "paid bills regardless of their reasonability, that action would, in fact *be in violation of the insurance contract.*" 214 Mich App at 582, 543 NW2d at 44 (emphasis added). The *LaMothe* court added "this scrutiny by the insurance company" -- *i.e.,* the review of medical bills for reasonableness and necessity -- "would be compelled even if the contract itself did not provide for it because the statute controlling these contracts for automobile insurance requires it. . . . Thus, *not only should an insurer audit and challenge the reasonableness of bills submitted by health care providers, but the providers should expect no less.*" *Id.* n3 (emphasis added).

In addition, consistent with these cases, the Insurance Commissioner issued a Bulletin instructing no-fault insurers to intervene when a provider seeks to collect from an insured so that the insured is not exposed to such collection activity. *See* Michigan Insurance Bureau Bulletin 92-03. This Bulletin, which, as an agency interpretation, is entitled to deference (*see McGill*, 207 Mich App at 407, n1, 526 NW2d at 14 n1), reflects the Commissioner's recognition that insurers have the right and obligation to review medical bills, and not to pay the full amounts to the extent those amounts are unreasonable or unnecessary. Otherwise, the Commissioner would not have instructed insurers to protect their insureds in the event of a provider dispute over payment.

If this Court reverses the Court of Appeals' decision, as plaintiffs have asked it to do, medical providers will truly have carte blanche to charge whatever fees they want. Michigan insurers' ability to contain costs, which, as noted, they are *required* to do under the No Fault Act, would be compromised. As a result, the insurers' ability to control their loss exposure would be hampered, and, in turn, the premiums they must charge their insureds for no-fault insurance

would no doubt increase. *See, e.g.,* "No Fault Auto Insurance In Michigan," published by the Insurance Information Association of Michigan, *http://www.fmic.com/Tips/nofault.htm* (noting that the "Michigan no-fault system has effectively held down costs while still allowing people with grave injuries access to justice," but that "premiums have increased steadily in recent years" due, in part, to the "inflation in the costs of health care").

Put simply, the negative impact on Michigan insurers and insureds of a reversal in this case would be severe. Indeed, the only winners would, in direct contravention of the No Fault Act, be medical providers who charge unreasonable or unnecessary fees.

II. CONTRARY TO PLAINTIFFS' CONTENTION, THE COURT OF APPEALS DID NOT RULE THAT THE "80th PERCENTILE TEST," WHICH PLAINTIFFS MISCHARACTERIZE IN ANY EVENT, IS THE *ONLY* METHOD FOR EVALUATING THE REASONABLENESS OF MEDICAL EXPENSES, OR IS ALWAYS APPROPRIATE.

Unable to avoid the settled Michigan law which *requires* insurers to review medical bills for reasonableness and necessity, plaintiffs now argue that the methods defendants use to evaluate bills are improper, focusing solely on the "80th percentile test," which they completely mischaracterize. Until now, however, plaintiffs have never even alleged, let alone established, that there is anything improper about *any* of the particular methods defendants use to evaluate medical bills.[1]

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[1] The Sixth Circuit expressly recognized plaintiffs' failure in this regard, stating plaintiffs "alleged no facts tending to show that the fees charged by the providers were 'reasonable' (or that the amounts paid by the insurance companies were 'unreasonable'), and Michigan law clearly states that health care providers are permitted to charge only a 'reasonable' amount for auto-accident related medical care when the patient is covered by no-fault insurance. Thus, what the providers received from the Defendants may very well have been all they were entitled to receive under Michigan's no-fault act. Other than their general allegation of fraud, Plaintiffs allege no facts indicating that the providers' fees, rather than the insurance companies' payments, were the 'reasonable' figures; the general allegation is not sufficient to satisfy Rule 9(b). The 'reasonableness' of these charges is a legal conclusion, wholly unsupported by allegation of fact, and therefore it need not be accepted as true for purposes of 12(b)(6) review." *Advocacy Org. of Patients & Providers v Auto Club Ins Ass'n,* 176 F3d 315, 320 (6th Cir.), *cert denied,* 528 US 871 (1999) (citations omitted).

Moreover, contrary to plaintiffs' suggestion, the Court of Appeals did not rule that the 80th percentile test, or any other method, is the *only* method insurers may use to evaluate reasonableness. Nor did it preclude medical providers or insureds from challenging an insurer's assessment of the reasonableness of any given bill. Rather, the Court of Appeals held *only* that insurers have the right to review medical bills for reasonableness and that, consistent with the principle that the plaintiff has the burden of proving the bill is reasonable, whether the amount charged is reasonable must be determined on a case-by-case basis by the trier of fact.

Plaintiffs argue the "80th percentile test" is "unacceptable, because it arbitrarily identifies 20% of providers charges as 'unreasonable,' regardless of how high or low they are." (Plaintiffs' Brief at 2.) In addition, plaintiffs try to equate the "80th percentile test" with the types of fee schedules (*i.e.*, schedules based on the amounts insurers have *paid*, as opposed to the amounts providers have charged) some courts have held may not be used to evaluate "customary" medical charges. (*Id.* at 24.) Plaintiffs are wrong on both points.

A. The Percentile Test Is Widely Accepted.

Significantly, like the lower courts here, courts in other jurisdictions have found the percentile test a valid and useful method for reviewing medical bills. For example, in *In re Estate of Albergo*, 275 Ill App 3d 439, 656 NE2d 97 (2d Dist 1995), the patient's estate and insurance company refused to pay the plaintiff hospital's bill based on a report the defendant bill review service provided. *Id.* at 441, 656 NE2d at 100. Relying on a computer database and a percentage-based figure to evaluate the medical charges, the defendant found that many of the plaintiff hospital's charges exceeded the reasonable cost of the services provided. *Id.* at 442, 449, 656 NE2d at 101, 106. The hospital sued the defendant for tortious interference with contract and violation of the Consumer Fraud Act. *Id.* at 442, 656 NE2d at 101.

The court held this type of bill review was a lawful way to determine reasonableness and that the defendant engaged in no deception: "Plaintiff does not explain why a markup of more than 50% over cost may not be deemed excessive or unreasonable. . . . Plaintiff's argument that its definition of reasonableness is the correct definition and that defendants should therefore have used that definition does not change our conclusion." *Id.* at 450-51, 656 NE2d at 106. Accordingly, the court found that the bill review company did not engage in deceptive practices and the bill review was not a "sham," even though the defendant's definition of reasonableness did not match the plaintiff's. *Id.* at 450-51, 656 NE2d at 106. *See also Nager v Allstate Ins Co*, 83 Cal App 4th 284, 290-92, 99 Cal Rptr 348, 354-56 (2000) (finding compelling public policy reasons why insurers should not provide a blank check for outstanding medical bills, and specifically holding there was nothing tortious about the defendant insurer's use of a computerized billing program as a tool to assist in measuring the reasonableness of medical bills); *State Farm Mut Auto Ins Co v Sestile*, 821 So 2d 1244 (Fla 2d DCA 2002) (reversing trial court's ruling that an insurer could not decline to pay less than the full amount of a medical bill based solely on a computerized bill review).

B. Plaintiffs Have Mischaracterized the Percentile Test.

Moreover, as the Court of Appeals correctly recognized, the 80th percentile test does *not* merely slash 20 percent from all providers' bills. Rather, the test is used to "recommend payment of one hundred percent of the charges as long as the charge does not exceed the highest charge for the same procedure *charged* by eighty percent of other providers rendering the same service." *Advocacy Org of Patients & Providers v Auto Club Ins Ass'n* ("*AOPP*"), 257 Mich App 365, 381-82, 670 NW2d 569, 579 (2003) (underscored emphasis added). For instance, if a charge is in excess of the 80th percentile (that is, the charge is higher than the amount *charged* by 80% of other providers) for similar services by similar treating providers in the provider's

geographic area, an insurer may determine the charge is unreasonable. As with other bill review methods, however, insurers may or may not choose to follow that recommendation with respect to any particular charge.

Insurers' claims adjusters, for instance, still use their independent judgment in evaluating claims. The "percentile test" and other bill review methods are simply tools to assist in that evaluation, and the adjusters can, and often do, override the percentile-based fee recommendation. In fact, nothing in the record in this case suggests insurers who use the percentile test blindly follow percentile-based fee recommendations, as opposed to making case-by-case determinations, with the percentile recommendation being only one factor considered.

C. The Percentile Test Is Based On Charge Data, Not Payment Data.

As the Court of Appeals correctly observed, the 80th percentile method cannot be equated with fee schedules based on amounts insurers have *paid*, since the percentile formula is based on the amounts providers have *charged*. That is why, as defendants argued below, and as the Court of Appeals explained, the "fee schedule" cases plaintiffs have cited are inapposite:

> *Mercy Mt. Clemens Corp. v. Auto Club Ass'n,* 219 Mich App 46 555 NW2d 871 (1996), is of no consequence to plaintiffs' argument. The *Mercy Mt. Clemens* Court held that the amounts health-care providers **accepted as payment** in full from various third-party payers, such as Medicare, Medicaid, Blue Cross, worker's compensation carriers, HMOs, and PPOs, were irrelevant in determining whether the amounts health-care providers *charged* were reasonable and customary under § 3157. Indeed, the panels in *Mercy Mt. Clemons, Munson,* and *Hofmann* each concluded that the **data regarding payments made by third-party payers** could not be used to determine the customary *charge* under § 3157. In contrast, this case involves defendants' review of plaintiffs' medical charges for reasonableness under § 3107 by comparing plaintiffs' charges to those of other providers for similar services.

AOPP, 257 Mich 382, 670 NW2d at 579 (bold emphasis added) (*citing Mercy, supra*; *Munson Medical Center v Auto Club*, 218 Mich App 387; 554 NW2d 49 (1996); *Hofmann v Auto Club*

Ins Ass'n, 211 Mich App 55; 535 NW2d 529 (1995)). *See also Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536, 542 n3, 637 NW2d 251, 254 n3 (2001) (noting that *Munson* and *Hofmann* involved an interpretation of the meaning of "customary charges," and that both cases held no-fault insurers "could not refer to *amounts paid* by other insurance companies [and third-party payers] as a benchmark for determining the amounts of its own payments of customary charges under § 3157") (emphasis added).

In other words, as the Court of Appeals correctly noted, the fee schedules at issue in cases such as *Mercy* were objectionable because they compared provider charges to amounts *paid* for such charges, not to amounts *charged* by other providers – *i.e.,* the same type of charge data on which the 80th percentile test is based. Plaintiffs argue this "distinction between 'charge' and 'payment'" is an "artificial" one. (Plaintiffs' Brief at 24.) However, this argument is totally contradicted by the very cases on which they rely. The courts in *Mercy, Munson* and *Hofmann* obviously found nothing artificial about the distinction between using a measure of amounts paid, as opposed to amounts charged by providers, to evaluate customary charges as opposed to reasonableness. Otherwise, these courts would not have expressly rejected the argument that "payments from [third-party payers] for services, as opposed to the original charges made by the health-care providers, were the proper criteria" for determining the 'customary charge' for those services." *Mercy*, 219 Mich App at 53, 555 NW2d at 874 (*citing Hofmann*). In addition, since, as noted above, insurers do not uniformly accept percentile-based fee recommendations, the percentile test certainly cannot be equated with a "fee schedule."

Moreover, contrary to plaintiffs' and their amicis' contention,[2] the Court of Appeals' decision acknowledging insurers' right to review medical bills for reasonableness is wholly

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[2] *See* Plaintiffs' Brief at 2, Amicus Curiae Brief of Michigan Health and Hospital Association at 3-5; Amicus Curiae Brief of Michigan State Medical Society at 3-9; Amicus Curiae Brief of the Coalition Protecting Auto No Fault ("CPAN") at 10-12.

consistent with cases such as *Mercy*, *Munson* and *Hofmann*. In *Mercy*, the court addressed the proper criteria for evaluating a hospital's "customary" charge, but emphasized that the no fault scheme did not permit a provider to charge more than a reasonable fee. 219 Mich App at 51, 52, 555 NW2d at 873. In *Munson*, the court noted that the only issue before it was the meaning of a "customary charge," but specifically stated the "statutory qualification of reasonableness limits the amount that must be paid by a no-fault carrier for covered medical expenses," 218 Mich App at 382, 384, 554 NW2d at 52. And in *Hofmann*, the Court made it clear that the tests for "customary" and "reasonableness" are separate tests, and that insurers are liable only for reasonable bills. 211 Mich App at 114, 535 NW2d at 557 ("[i]In addition to the 'customary charge" limitation discussed above, §§ 3107 and 3157 also impose a statutory qualification of reasonableness, such that a no-fault carrier is liable only for those medical expenses that constitute a reasonable charge for the product or service") (*citing Nasser, supra*). *See also AOPP,* 176 F3d at 320 (noting difference between "customary" and "reasonable" tests discussed in *Hofmann*).[3]

Similarly, in *Johnson v Michigan Mut Ins Co*, 180 Mich App 314, 335 NW2d 899 (1989), another case plaintiffs and their amici cite, the only issue was whether the fee amounts the hospital accepted from Medicaid constituted the hospital's customary charge. *Id.* at 321, 335 NW2d at 901. The court ruled that a "customary" charge was evaluated by charges made to other injured persons "in cases not involving insurance." The court did not address the test for reasonableness, because the reasonableness of the charges was not in dispute. So, the Court of Appeals' conclusion that insurers may review medical bills for reasonableness, including using the percentile method, was entirely consistent with these cases.

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[3] Indeed, the courts' emphasis on the difference between the "customary" and "reasonableness" factors wholly negates Michigan State Medical Society's argument that the "juxtaposition of [these factors] in the statute implies that the reasonableness of the fee is to be determined, at least in part, by the provider's customary charge." (Michigan State Medical Society's Brief at 12.)

In any case, contrary to plaintiffs' and their amicis' contention, the Court of Appeals did not rule that an insurer's payment decision based on the 80th percentile test is always right or always wrong. It merely held that this bill review method "is not prohibited by the statute for determining the reasonableness of charges for the same service." 257 Mich App at 382, 670 NW2d at 579. If an insurer chose not to pay the full amount of a provider's bill based on the 80th percentile test, the provider would certainly not be precluded from disputing that payment decision. As the Court of Appeals correctly recognized, however, such a dispute cannot be resolved on a global basis, as plaintiffs have attempted to do in this case by securing a ruling that insurers cannot review and reduce bills at all. Rather, the reasonableness of any particular medical bill would have to be determined on a case-by-case basis, which is wholly consistent with the principle, discussed above, that plaintiffs have the burden of proving the reasonableness of their medical expenses in the first instance. 257 Mich App at 380, 670 NW2d at 578.

Indeed, once the principle that insurers have the right to review medical bills is accepted -- a principle clearly established by this Court's decision in *Nasser* -- disputes regarding insurers' payment decisions would *have* to be resolved individually. The Legislature could have amended the No Fault Act to include a precise definition of "reasonableness," or adopted some sort of fee schedule. Since it did not, the only way insurers can review bills, and the only way the insurers' ultimate payment determination can be assessed, is on a case-by-case basis.[4]

[4] Indeed, one of plaintiffs' amicus curiae, CPAN, makes this very point, arguing "the question of reasonableness is a factual matter and one to be determined by the individual facts of each case." Amicus Curiae Brief of CPAN at 7. As discussed herein, however, contrary to CPAN's argument, the Court of Appeals' decision clearly reaffirmed this principle, specifically holding, consistent with this Court's decision in *Nasser*, that insurers can review bills, and if there is a dispute between the insurer and the provider over the insurer's determination, it is for the trier of fact to determine whether any given charge is reasonable.

III. THE COURT OF APPEALS CORRECTLY RECOGNIZED THAT THE NO FAULT ACT REQUIRES INSURERS TO REVIEW MEDICAL BILLS FOR REASONABLENESS WITHOUT MANDATING ANY PARTICULAR FORM OF REVIEW.

Plaintiffs' and their amicis' focus on the 80th percentile test is a red herring in any event. Contrary to their suggestion, the Court of Appeals certainly did not rule that test is the only method for reviewing bills. In fact, the Court emphasized it was doing no such thing:

> [W]e hold that the statute requires that an insurer only pay on behalf of the insured a "reasonable" charge for the particular product or service. However, *the Legislature has not defined what is "reasonable" in this context, and, consequently, insurers must determine in each instance whether a charge is reasonable in light of the service or product provided.* It may be that a health-care provider's "customary" charge is also reasonable given the services provided, while at other times the "customary" charge may be too high, and thus unreasonable. Either way, the trier of fact will ultimately determine whether a charge is reasonable. *Nasser*, *supra* at 55, 457 NW2d 637.
>
> *We will not attempt to delineate the permissible factors for determining what is "reasonable," because it is not necessary to do so in resolving plaintiffs' arguments.* Defendants in this case have not refused to pay health-care benefits due plaintiffs. To the contrary, defendants paid what they believed to be the reasonable charges incurred for reasonably necessary products, services, and accommodations for their insureds' care. Under the foregoing case law, defendants are allowed to pay the reasonable amount and contest the claim under the act without penalty where a reasonable dispute exists regarding the amount of benefits owing.

Id. at 379-80, 670 NW2d at 577-78 (emphasis added, footnote omitted).

In other words, the Court of Appeals simply held, as it had to under the Michigan No Fault Act and the relevant case law, most notably this Court's unambiguous decision in *Nasser*, that insurers have the obligation to review medical bills for reasonableness and necessity, and the right to do so using any reasonable method -- not just the 80th percentile -- to facilitate that evaluation. The Court did not rule, though, that an insurer's payment decision in any given case,

based on *any* particular bill review method, would always be right, and it expressly acknowledged providers' ability to dispute the insurers' reasonableness determination.

That is why plaintiffs' and their amicis' argument that the Court of Appeals has impermissibly allowed insurers to "unilaterally" set a reasonable charge based on the 80th percentile test (or any other method)[5] is groundless. The Court of Appeals' ruling does no such thing. Instead, the Court simply recognized that insurers are not required to pay any charge that is unreasonable or unnecessary, as well as their right and obligation, under the no fault scheme, to audit medical charges to ensure they are, in fact, reasonable and necessary. And, since the Court of Appeals' decision clearly preserves the providers' right to dispute the insurers' reasonableness determination, it certainly does not allow insurers to "unilaterally" determine anything.

Specifically, quoting this Court's decision in *Nasser*, *supra,* the Court of Appeals stated the "reasonableness of the charge is an explicit and necessary element of a claimant's recovery against an insurer, and, accordingly, the burden of proof on this issue lies with the plaintiff. Where a plaintiff is unable to show that a particular, reasonable expense has been incurred for a reasonably necessary product and service, there can be no finding of a breach of the insurer's duty to pay that expense, and thus no finding of liability with regard to that expense." *Id.* at 374, 670 NW2d at 575 (*quoting Nasser,* 435 Mich at 50, 457 NW2d at 637).

Plaintiffs complain the Court of Appeals' decision "requires that every fee dispute be litigated individually, an approach that will needlessly increase the cost of health care and no fault insurance." (Plaintiffs' Brief at 2.) Yet, as set forth above, such disputes would, under *Nasser, have* to be resolved on a case-by-case basis because of the providers' burden of showing reasonableness and necessity. Indeed, the lower court recognized the need for such case-by-case

[5] *See* Plaintiffs' Brief at 20-23, Amicus Curiae Brief of Michigan Health and Hospital Association at 9; Amicus Curiae Brief of Michigan State Medical Society at 17.

resolution when it denied plaintiffs' motion for class certification -- a decision plaintiffs have *not* appealed.[6]

In addition, contrary to plaintiffs' argument, the courts will not be flooded with provider suits if the Court of Appeals' decision is allowed to stand. Under Michigan law, insurers have been allowed to review medical bills for reasonableness and necessity for years, and the courts have certainly *not* been inundated with such suits. Indeed, the fact that there has been no such flood of provider litigation reflects PCI's belief that, in the vast majority of cases, providers accept the insurers' determination regarding the reasonableness and necessity of medical bills, so the no fault system is working precisely as it should. Specifically, insurers perform a valuable cost-policing function by reviewing medical bills, which, in turn, preserves insureds' limited no-fault coverage and keeps premiums down.

In reality, the approach plaintiffs advocate, *not* the Court of Appeals' decision, would needlessly increase the cost of no fault insurance. If the Court of Appeals' decision -- which, again, simply reaffirms insurers' right to review medical bills for reasonableness and necessity, and to refuse to pay unreasonable or unnecessary amounts -- is reversed, the insurers' cost-policing ability would be eliminated. If insurers are prohibited from reviewing and challenging medical bills on reasonableness and necessity grounds, the cost of providing no-fault insurance would increase exponentially for all Michigan no-fault insurers, as would the corresponding premiums for all Michigan insureds. To paraphrase *McGill, supra,* that result would "directly conflict with the Legislature's purpose in enacting the no-fault system," since the "Legislature did not intend for no-fault insurers to pay all claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud." *McGill*, 207 Mich App at 408, 526 NW2d at 14.

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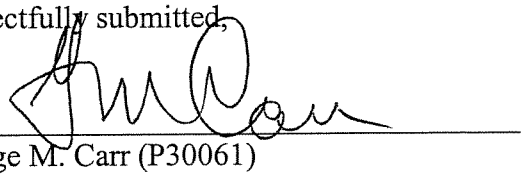
[6] So, even if plaintiffs were to win this case, there would still have to be a case-by-case determination of reasonableness and necessity of all disputed charges, meaning plaintiffs' desired result would be no more streamlined than the result reached by the Court of Appeals.

In a nutshell, the Court of Appeals' decision merely reaffirms what Michigan courts, including this Court in *Nasser*, have always held – *i.e.*, that insurers are only liable for reasonable and necessary medical charges, and that they have the right and obligation to review medical bills for reasonableness and necessity. As the Court of Appeals also recognized, insurers may still be held liable if the finder of fact concludes their payment decision was wrong. That determination, however, must be made on a case-by-case basis; it cannot and should not be resolved globally for all insurers and every no-fault claim by declaring any particular bill review method invalid, or, worse yet, precluding bill review altogether. Yet, that is precisely the result plaintiffs advocate by seeking reversal of the Court of Appeals' decision.

RELIEF REQUESTED

Amicus curiae, the Property Casualty Insurers Association of America, respectfully requests that the Court of Appeals' decision, which is completely consistent with the No Fault Act and the numerous Michigan cases construing it, be affirmed.

Respectfully submitted,



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